pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:

[redacted]

Date of Birth: 11/25/15
Date of Incident: 01/30/17
Date of Report to ChildLine: 01/30/17
CWIS Referral ID: [redacted]

FAMILY NOT KNOWN TO COUNTY CHILDREN AND YOUTH AGENCY AT TIME OF INCIDENT OR WITHIN THE PRECEDING 16 MONTHS:

Lehigh County Children and Youth Services

REPORT FINALIZED ON:
07/17/2017

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.
(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.
(23 Pa. C.S. Section 6349 (b))

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Reason for Review:

Pursuant to the Child Protective Services Law, the Department, through OCYF, must conduct a review and provide a written report of all cases of suspected child abuse that result in a fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

The Child Protective Services Law also requires that county children and youth agencies convene a review when a report of child abuse involving a fatality or near fatality is substantiated or when a status determination has not been made regarding the report within 30 days of the report to ChildLine.

Lehigh County has convened a review team in accordance with the Child Protective Services Law related to this report. The county review team was conducted on 02/16/2017.

Family Constellation:

First and Last Name:	Relationship:	Date of Birth
[redacted]	Victim child	11/25/2015
[redacted]	Maternal Aunt	[redacted]1981
[redacted]	Maternal Uncle	1975
[redacted]	Cousin	2011
[redacted]	Cousin	2013
* [redacted]	Biological Mother	1979

Currently incarcerated in [redacted] Prison, [redacted] North Carolina

*Denotes an individual that is not a household member or did not live in the home at the time of the incident, but is relevant to the report.

Summary of OCYF Child Near Fatality Review Activities:

The Northeast Region Office (NERO) received the initial notification of a child near fatality from Lehigh County Children and Youth Services on 01/31/2017. The NERO investigated and reviewed records pertaining to the family. On 02/08/2017, an interview of the assigned CPS caseworker by the NERO program representative was conducted at county agency. The safety plan and status of the investigation was discussed. Law enforcement issued a warrant for the maternal aunt related to the current investigation. The county agency is also attempting to secure prior case history on the perpetrators from Berks County and Bucks County where there is a record of prior residency.

An Act 33 near fatality review was conducted at Lehigh County Children and Youth Services on 02/16/2017. The NERO attended the Act 33 meeting. A site visit was also conducted on this same date. The assigned CPS caseworker was interviewed by NERO and the current status of the CPS investigation was reviewed. Once more the current status of the CPS investigation was reviewed during an in person

meeting between NERO and the assigned Lehigh County Children and Youth CPS caseworker on 02/22/2017. Lehigh County Children and Youth completed the CPS investigation on 04/15/2017.

Children and Youth Involvement prior to Incident:

There is no record of service activity with this family in Lehigh County.

Circumstances of Child Near Fatality and Related Case Activity:

This case involves the care and supervision of a sixteen month old child that has been in the custody of her maternal aunt pursuant to an informal transfer of custody of the child by the biological mother prior to her incarceration in North Carolina. The current caretakers went to North Carolina in April 2016 and brought the victim child back to Lehigh County. This arrangement was informal and there has been no social service activity with either the victim child or family until the current allegations associated with the near fatality dated 01/30/2017.

On 01/30/2017, the victim child was transported to the emergency room of a local hospital by Emergency Medical Services personnel after responding to a call from the victim child's maternal aunt, current custodian. According to the information provided by the maternal aunt, the victim child had two seizures on the day of the incident. Upon admission to the hospital the victim child was observed to be malnourished and to have evidenced bruising on multiple parts of her body. The maternal aunt attributed the bruising to the victim child's propensity to "fall".

[redacted]

When the medical findings were reviewed with the caretakers, they were not forthright in the provision of information. The information secured from the maternal aunt and uncle was contradictory in nature and did not coincide with the medical findings. At this point in the investigation, Lehigh County Children and Youth Services determined a safety plan was necessary for the victim child and biological children of the perpetrators. [redacted]

[redacted] During the stay in this program Lehigh County Children and Youth Services identified a foster care resource for the victim child. The victim child was [redacted] to this family where she continues to be maintained. Overall, the victim child has made noticeable improvements in physical health and overall functioning.

Lehigh County Children and Youth Services continues to provide foster care placement to the victim child and the perpetrators' two biological children. All three children remain in the same placement setting. Permanency planning continues to be provided to all three children with the primary goal of reunification and a concurrent goal of adoption.

On 3/15/17, the case was assigned an indicated status, naming both the maternal aunt and her husband as perpetrators of physical abuse for causing serious physical neglect of a child through failure to provide medical treatment/care and failure to provide nutrition and hydration. The maternal uncle is currently incarcerated in [redacted] Prison on charges derived from the physical abuse of the victim child. He is awaiting a trial on charges of endangering the welfare of children and simple and aggravated assault. The maternal aunt was not criminally charged in relation to the child abuse investigation involving the victim child.

County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Near Fatality Report:

- Strengths in compliance with statutes, regulations and services to children and families;
  As of the writing of this report by the NERO the county agency has not submitted the County Near Fatality Report.

- Deficiencies in compliance with statutes, regulations and services to children and families;
  As of the writing of this report by the NERO the county agency has not submitted the County Near fatality report.

- Recommendations for changes at the state and local levels on reducing the likelihood of future child fatalities and near fatalities directly related to abuse;
  As of the writing of this report by the NERO the county agency has not submitted the County Near Fatality report.

- Recommendations for changes at the state and local levels on monitoring and inspection of county agencies; and
  As of the writing of this report by the NERO the county agency has not submitted the County Near Fatality Report.

- Recommendations for changes at the state and local levels on collaboration of community agencies and service providers to prevent child abuse.
  As of the writing of this report by the NERO the county agency has not submitted the County Near Fatality Report.

Department Review of County Internal Report:

The NERO has not received the Near Fatality Report from Lehigh County Children and Youth Services as of the date of the preparation of this review.

Department of Human Services Findings:

- County Strengths:

  Lehigh County Children and Youth Services commenced a Child Protective Services investigation in a timely and methodic manner. The assigned caseworker appropriately assessed all children within the family unit in a timely and comprehensive manner.

  The instant case specifics involved a rather complex series of medical issues and familial relationships that the assigned CPS intake caseworker was able to analyze. The assessment was thorough and involved consistent collaboration with the law enforcement agency conducting the criminal investigation. Case file documentation was timely and clearly reflected the many facets of the investigation/service delivery issues related to the victim child and the other children within the perpetrators' household.

  Case file documentation also evidenced an active engagement of the biological mother in the case process despite her incarceration out of state. Through the interventions of the Lehigh County Children and Youth CPS intake caseworker the biological mother was able to come to Pennsylvania and visit with the victim child. Permanency planning has been initiated with the biological mother immediately at the onset of the county agency becoming involved in the CPS investigation.

- County Weaknesses: and

  N/A

- Statutory and Regulatory Areas of Non-Compliance by the County Agency.

  Lehigh County Children and Youth Services has not submitted a County Near Fatality Report on this case to the NERO as of the NEROs preparation of this report.

Department of Human Services Recommendations:

OCYF/NERO continues to recommend that Lehigh County Children and Youth conduct Child Protective Services investigations in a manner consistent with the procedures, case practice and thoroughness evidenced in this case.

It is also recommended that the county agency continue to work in a collaborative manner with the law enforcement agency as was also clearly manifest in this case.

While OCYF/NERO has not received a formal Act 33 submission from Lehigh County regarding this case there was considerable discussion at the Act 33 Review regarding the circumstances surrounding victim child's relocation to Pennsylvania from North Carolina, especially relating to the informal nature of the transfer and the subsequent lack of oversight of the victim child's care.

The NERO also concurs with the discussion presented at the county Act 33 meeting related to the service gaps that occurred at the onset of the victim child's entry into the care/custody of the perpetrators in Pennsylvania. Given the circumstances surrounding the incarceration of the biological mother of the victim child in North Carolina, it is not clear if authorities in North Carolina were aware of the plan. It's also not clear if there are any safeguards in place to ensure that children are placed with fit and willing resources. It is recommended that there be a more global review of this process to ensure that situations like this are not replicated.